Steven E. Locke, MD, DLFAPA

10 Deer Run, Wayland, MA 01778

(508) 343-0001 Phone | (508) 213-3776 Fax

steven.locke@drstevenlocke.com | www.drstevenlocke.com

CONSENT FOR USE OF MEDICATION

I understand that during my treatment by Dr. Locke, he may recommend medication as a treatment option when it has been found to be effective in treating patients with symptoms or conditions like mine. I have the right to accept or refuse medication. Medication has the potential for both risks and benefits. We have discussed the reasons using specific medications might help me and the known, associated risks. I understand that some medication-related risks are rare or even unknown, and I accept those risks following my discussion with Dr. Locke. I am making an informed choice to take the medication(s) he has suggested, according to the instructions provided.

Dr. Locke has reviewed the issues related to my use of the medication(s). I have had the opportunity to ask questions and he has answered them to my satisfaction. He has explained:

1. the reasons for taking the medication including which of my symptoms or conditions are being treated and how the medication might help;
2. the likelihood of improving with medication or the likelihood of not improving or worsening without the proposed medication, as well as the risks of stopping it too soon;
3. alternatives to treatment with medication, if such options are available;
4. my right to withdraw consent at any time by informing him during a phone call, in writing, or during an office visit;
5. the type, frequency and dosage (including the use of PRN or "as needed" medications), method or route (for example, by mouth or injection), and expected length of time of taking the medication(s);
6. the known common and serious side effects of these medications and possible side effects if taken longer than 3 months;
7. how he monitors for the possibility of adverse drug interactions or new adverse effects of drugs as they become known.

I understand that treatment is a partnership and that both the doctor and the patient have responsibilities in order for treatment to be helpful. With regard to my responsibilities, I agree to:

1. read the information that is attached to the medication when I get it from the pharmacy, and, if I have any questions or concerns, to contact Dr. Locke before starting the medication. Dr. Locke has provided his mobile phone number and told me to contact him any time;
2. read any additional patient education material provided or recommended to help me to better understand my condition and its treatment;
3. take my medication as instructed and to report promptly to Dr. Locke any new symptoms, side effects or adverse reactions;
4. not stop a medication without discussing it in advance with Dr. Locke, unless it is an emergency (e.g., an allergic reaction or serious side effect);
5. discuss with Dr. Locke any changes in dose or frequency of the prescribed medication;
6. inform Dr. Locke of any new medications that I am taking, either over-the-counter medications or nutrition supplements or herbal remedies or new medications prescribed by other clinicians;
7. notify Dr. Locke if another doctor recommends stopping a medication prescribed by Dr. Locke.

SIGNATURE OF PATIENT OR GUARDIAN	DATE
PATIENT PRINTED NAME	DATE OF BIRTH
	
SIGNATURE OF PROVIDER: STEVEN LOCKE, MD	DATE